MONROE COUNTY
EMPLOYEE DENTAL PLAN

HIRE_____ **DATE_____**

UNCD_____

_____NEW APPLICATION _____CANCEL _____ADDRESS CHANGE _____NAME CHANGE

_____ADD DEPENDENTS _____REMOVE DEPENDENTS

DEPT_____ **SS #_____**

NAME_____ **D.O.B._____**

ADDRESS_____

CITY/STATE/ZIP_____ HOME PHONE_____

SPOUSE'S NAME_____ SS #_____ D.O.B._____

DEPENDENT CHILDREN: (PLEASE SPECIFY IF THEY ARE COLLEGE STUDENTS AND WHAT COLLEGE THEY ARE ATTENDING; OR IF THEY ARE HANDICAPPED.)

NAME	D.O.B.	NAME OF COLLEGE
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

IS THERE DENTAL INSURANCE COVERAGE FOR YOURSELF, YOUR SPOUSE, OR YOUR DEPENDENT CHILDREN OTHER THAN MONROE COUNTY? _____YES _____NO

IF YOU ANSWERED YES TO THE ABOVE QUESTION, PLEASE INDICATE THE NAME OF THE INSURANCE CARRIER, NAME OF THE CONTRACT HOLDER, CONTRACT NUMBER, AND NAME OF THE EMPLOYER OR GROUP ON THE REVERSE SIDE OF THIS APPLICATION.

IT IS YOUR RESPONSIBILITY TO KEEP ALL DATA REQUESTED ON THIS APPLICATION CURRENT AND TO REPORT ANY CHANGES IN STATUS TO THE HUMAN RESOURCES DEPARTMENT. FAILURE TO REPORT CHANGES MAY RESULT IN A DELAY IN PAYMENT OF BENEFITS.

_____I HEREBY AUTHORIZE MONROE COUNTY TO MAKE PAYROLL DEDUCTIONS IN THE AMOUNT APPROVED FOR THE COVERAGE SELECTED.

SIGNATURE_____ DATE OF ELIGIBILITY OR CHANGE_____